



City of Long Beach

Health/Dental Insurance Selection Form

No Changes	Current Plans	Action	Health	In-Hospital Indemnity	Long Term Care
If you are not making any changes, Check here <input type="checkbox"/> And sign the form.	Health:	Indicate all actions that apply: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA Enrollment <input type="checkbox"/> Plan Change <input type="checkbox"/> Name/Address Change <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent	Enroll or change to: POS <input type="checkbox"/> Long Beach Choice POS <input type="checkbox"/> Great West POS	Enroll or change to: <input type="checkbox"/> (01) Employee Only <input type="checkbox"/> (03) Employee & Spouse <input type="checkbox"/> (04) Employee & Domestic Partner <input type="checkbox"/> (05) Employee & Child(ren) <input type="checkbox"/> (07) Employee & Family	Are you interested in signing up for Long Term Care? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Dental:		PPO <input type="checkbox"/> Great West Value <input type="checkbox"/> Great West High <input type="checkbox"/> Great West Low	<input type="checkbox"/> Decline/Terminate Coverage	Note: New employees are guaranteed a policy for themselves within 30 days of hire.
	In-Hospital Indemnity:		HMO <input type="checkbox"/> PacifiCare		Employees and spouses must complete a medical questionnaire (included in application package) as part of the application process.
			Dental		
			Enroll or change to: <input type="checkbox"/> Delta <input type="checkbox"/> PacifiCare		

Form Effective Date:	Payroll Deduction:	040 Amount	\$	044 Amount	\$
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Name (Last, First, M.I.)	Birth date	Do you or any dependents have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If any dependents live at a different address, please indicate: Name Complete Address Name Complete Address Name Complete Address
Address	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
City, State, Zip	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
Home Phone Social Security No.	Marriage/Divorce Date:		
Dept/Bur/Div Hire Date		Policy No.	
		Employer Name (if applicable)	

LIST SELF AND DEPENDENTS (if applicable)							POS/HMO Only			PacifiCare Dental Code
Relationship	Name	Add/Delete	SS No.	Birth date	Sex	PCP Name	Group Name or No.	Current Doctor		
				/ /	M F			Yes No		
				/ /	M F			Yes No		
				/ /	M F			Yes No		
				/ /	M F			Yes No		
				/ /	M F			Yes No		
				/ /	M F			Yes No		

Beneficiary Information:
If you are changing coverage due to a change in family status and need to change your beneficiary information, please check the appropriate box: ☐ Life Insurance ☐ PERS ☐ Deferred Compensation

Enrollment Agreement and Payroll Deduction Authorization
I acknowledge that the above information represents my enrollment choice(s). I understand that by signing this form I am electing to reduce my compensation in exchange for pre-tax health care coverage and I authorize payroll deductions for any required contribution. I understand my coverage elections cannot be changed until a future benefits enrollment period. I represent that to the best of my knowledge and belief, all statements and answers made on this form are true, complete and correct. If applicable, I hereby authorize any insurance company, hospital, physician or any other health care provider to release all information to all those who may have a bearing on benefits payable under this plan. Adjustments may be made to increase or decrease the amounts specified for deductions identified above by the City's Coding System, provided that the method, manner and amount of each such adjustment is in full compliance with the applicable laws or administrative rules and regulations of the City.

PacifiCare HMO Medical Coverage and PacifiCare Dental Coverage Agreement
If I elect medical coverage through PacifiCare HMO, I authorize anyone providing service to me or my eligible dependent(s) to release to PacifiCare HMO any information or medical records relating to those services. I agree that except for life-threatening emergencies, all medical services must be performed, prescribed, or authorized by my designated HMO provider. Enrollment in certain health plans constitutes an agreement to have a dispute decided by neutral arbitration and a waiver of any jury or court trial. Refer to the enrollment information to determine if and what types of disputes apply to the plan in which you have chosen to enroll. If this provision applies, your signature below means you agree to such arbitration for yourself and your enrolled dependents.

I understand and agree to the terms and conditions described above.

Employee Signature

Date